

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<div>I. IDPH Facility ID Number: 0041590</div> <div>Facility Name: INTERNATIONAL VILLAGE</div> <div>Address: 4815 SOUTH WESTERN A CHICAGO 60609</div> <div>County: COOK</div> <div>Telephone Number: (773) 927-4200 Fax # (773) 927-8742</div> <div>IDPA ID Number: 363928303001</div> <div>Date of Initial License for Current Owners: 09/11/00</div> <div>Type of Ownership:</div> <div><div><div>VOLUNTARY,NON-PROFIT</div><div>Charitable Corp.</div><div>Trust</div><div>IRS Exemption Code</div></div><div><div>X PROPRIETARY</div><div>Individual</div><div>Partnership</div><div>Corporation</div><div>"Sub-S" Corp.</div><div>X Limited Liability Co.</div><div>Trust</div><div>Other</div></div><div><div>GOVERNMENTAL</div><div>State</div><div>County</div><div>Other</div></div></div> <div><div>In the event there are further questions about this report, please contact:</div><div>Name:: Steve Lavenda Telephone Number: (847) 236 - 1111</div></div>	<div>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</div> <div>I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</div> <div>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</div> <div><div>Officer or Administrator of Provider</div><div>(Signed)</div><div>(Type or Print Name)</div><div>(Title)</div></div> <div><div>Paid Preparer</div><div>(Signed) See Accountants' Compilation Report Attached</div><div>(Print Name and Title) Edward Slack, CPA</div><div>(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</div><div>(Telephone) (847) 236-1111 Fax # (847) 236-1155</div></div> <div>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</div>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID NumberINTERNATIONAL VILLAGE

#0041590Report Period Beginning:01/01/02Ending:12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

1	2	3	4	
Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	218	Skilled (SNF)	218	79,570
2		Skilled Pediatric (SNF/PED)		
3		Intermediate (ICF)		
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	218	TOTALS	218	79,570

B. Census-For the entire report period.

1	2	3	4	5	
Level of Care	Patient Days by Level of Care and Primary Source of Payment				
	Public Aid Recipient	Private Pay	Other	Total	
8	SNF	6,647	440	7,093	14,180
9	SNF/PED				
10	ICF	35,056	3,565	394	39,015
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	41,703	4,005	7,487	53,195

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)66.85%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by Public Aid?0(Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)N/A

F. Does the facility maintain a daily midnight census?Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?YESNOX

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?YESNOX

I. On what date did you start providing long term care at this location?Date started9/11/00

J. Was the facility purchased or leased after January 1, 1978?YESXDate9/11/00NONO

K. Was the facility certified for Medicare during the reporting year?YESXNONOIf YES, enter number of beds certified28and days of care provided6,977

Medicare IntermediaryAdminaStar Federal

IV. ACCOUNTING BASIS

ACCUALXMODIFIEDCASH*CASH*

Is your fiscal year identical to your tax year?YESXNONO

Tax Year:12/31/02Fiscal Year:12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	194,162	21,329	18,287	233,778		233,778	(12,581)	221,197			1
2	Food Purchase		202,662		202,662		202,662	904	203,566			2
3	Housekeeping	114,577	25,446		140,023		140,023	(1,469)	138,554			3
4	Laundry	44,861	23,278		68,139		68,139		68,139			4
5	Heat and Other Utilities			206,155	206,155		206,155	1,377	207,532			5
6	Maintenance	60,729		207,738	268,467		268,467	1,082	269,549			6
7	Other (specify):*							1,381	1,381			7
8	TOTAL General Services	414,329	272,715	432,180	1,119,224		1,119,224	(9,307)	1,109,917			8
	B. Health Care and Programs											
9	Medical Director			8,250	8,250		8,250		8,250			9
10	Nursing and Medical Records	2,002,301	74,718	93,624	2,170,643		2,170,643	2,608	2,173,251			10
10a	Therapy	81,049	1,823	8,248	91,120		91,120	6	91,126			10a
11	Activities	90,728	6,399	6,265	103,392		103,392	24	103,416			11
12	Social Services	158,445		20,945	179,390		179,390	(13,160)	166,230			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							14,792	14,792			15
16	TOTAL Health Care and Programs	2,332,523	82,940	137,332	2,552,795		2,552,795	4,270	2,557,065			16
	C. General Administration											
17	Administrative	38,833		72,794	111,627		111,627	28,083	139,710			17
18	Directors Fees											18
19	Professional Services			356,917	356,917	(12,603)	344,314	(297,404)	46,910			19
20	Dues, Fees, Subscriptions & Promotions			90,870	90,870		90,870	(57,540)	33,330			20
21	Clerical & General Office Expenses	105,562	15,955	312,101	433,618		433,618	40,595	474,213			21
22	Employee Benefits & Payroll Taxes			475,036	475,036		475,036	(32,374)	442,662			22
23	Inservice Training & Education			397	397		397		397			23
24	Travel and Seminar			1,599	1,599		1,599	1,132	2,731			24
25	Other Admin. Staff Transportation			223	223		223		223			25
26	Insurance-Prop.Liab.Malpractice			256,067	256,067		256,067	969	257,036			26
27	Other (specify):*							28,804	28,804			27
28	TOTAL General Administration	144,395	15,955	1,566,004	1,726,354	(12,603)	1,713,751	(287,735)	1,426,016			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,891,247	371,610	2,135,516	5,398,373	(12,603)	5,385,770	(292,771)	5,092,999			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			92,015	92,015		92,015	410,806	502,821			30
31	Amortization of Pre-Op. & Org.			4,869	4,869		4,869	108,573	113,442			31
32	Interest			220,449	220,449		220,449	837,550	1,057,999			32
33	Real Estate Taxes			319,625	319,625	12,603	332,228	2,389	334,617			33
34	Rent-Facility & Grounds			926,991	926,991		926,991	(923,291)	3,700			34
35	Rent-Equipment & Vehicles			3,647	3,647		3,647	2,695	6,342			35
36	Other (specify):*							3,598	3,598			36
37	TOTAL Ownership			1,567,596	1,567,596	12,603	1,580,199	442,320	2,022,519			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		283,517	225,269	508,786		508,786	(5,642)	503,144			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			119,355	119,355		119,355		119,355			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		283,517	344,624	628,141		628,141	(5,642)	622,499			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,891,247	655,127	4,047,736	7,594,110		7,594,110	143,907	7,738,017			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(76,396)	30		9
10	Interest and Other Investment Income	(4,716)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(150)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	21		24
25	Fund Raising, Advertising and Promotional	(36,960)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(100)	20		28
29	Other-Attach Schedule	96,215			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (82,107)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	226,014		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 226,014		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 143,907		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS		Page 5A
INTERNATIONAL VILLAGE		
ID# 0041598		
Report Period Beginning:	01/01/02	
Ending:	12/31/02	
NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1 COPI	(1,609)	20 1
2 Misc Income	(186)	21 2
3 Collection Expense	(2,964)	21 3
4 Bank Charges	(1,292)	21 4
5 Theft Loss	(198)	21 5
6 Legal Fee (Bldg Co)	(219)	19 6
7 LLC Fee (Bldg Co)	(889)	21 7
8 Trust Fee (Bldg Co)	(98)	21 8
9 Health Insurance (PPA)	(2,125)	22 9
10 Service Contracts (PPA)	(820)	06 10
11 Capitalized R&M	(2,275)	06 11
12 Amortization of Pre-Operating Costs	168,573	21 12
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101 Total	96,215	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number INTERNATIONAL VILLAGE

0041590

Report Period Beginning:

01/01/02

Ending:

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary					(3,761)	(7)	(8,813)					(12,581)	1
2	Food Purchase	(150)		(119)			1,173						904	2
3	Housekeeping							(1,469)					(1,469)	3
4	Laundry													4
5	Heat and Other Utilities			1,377									1,377	5
6	Maintenance	(3,215)		2,694		1,593	10						1,082	6
7	Other (specify):*				197	782	402						1,381	7
8	TOTAL General Services	(3,365)		3,952	197	(1,386)	1,578	(10,282)					(9,307)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(33)	(1,199)	9,873	6	(6,039)					2,608	10
10a	Therapy				6								6	10a
11	Activities			2	22								24	11
12	Social Services				(13,171)	11							(13,160)	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				13,432	1,360							14,792	15
16	TOTAL Health Care and Programs			(31)	(910)	11,244	6	(6,039)					4,270	16
	C. General Administration													
17	Administrative			324	19	27,582	158						28,083	17
18	Directors Fees													18
19	Professional Services	(219)	219	(297,721)			317						(297,404)	19
20	Fees, Subscriptions & Promotions	(38,729)		(18,828)			17						(57,540)	20
21	Clerical & General Office Expenses	(65,130)	292	13,283	13,171	78,752	227						40,595	21
22	Employee Benefits & Payroll Taxes	(2,125)			(30,249)								(32,374)	22
23	Inservice Training & Education													23
24	Travel and Seminar			793			339						1,132	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			969									969	26
27	Other (specify):*				13,823	14,981							28,804	27
28	TOTAL General Administration	(106,203)	511	(301,180)	(3,236)	121,315	1,058						(287,735)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(109,568)	511	(297,259)	(3,949)	131,173	2,642	(16,321)					(292,771)	29

Summary B

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(76,396)	477,710	9,492									410,806	30
31	Amortization of Pre-Op. & Org.	108,573											108,573	31
32	Interest	(4,716)	832,142	10,124									837,550	32
33	Real Estate Taxes			2,389									2,389	33
34	Rent-Facility & Grounds		(926,991)	3,691			9						(923,291)	34
35	Rent-Equipment & Vehicles			2,682			13						2,695	35
36	Other (specify):*		3,598										3,598	36
37	TOTAL Ownership	27,461	386,459	28,378			22						442,320	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(5,642)						(5,642)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(5,642)						(5,642)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(82,107)	386,970	(268,881)	(3,949)	131,173	(2,978)	(16,321)					143,907	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
see attached		see attached		see attached		
				Highlander Care Center, LLC		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Expense	\$ 926,991	Highlander Care Center, LLC	100.00%	\$	(926,991)	1
2	V	32	Interest Expense		Highlander Care Center, LLC	100.00%	832,142	832,142	2
3	V	30	Depreciation		Highlander Care Center, LLC	100.00%	477,710	477,710	3
4	V	21	Misc Exp		Highlander Care Center, LLC	100.00%	2	2	4
5	V	36	Amortization		Highlander Care Center, LLC	100.00%	3,598	3,598	5
6	V	19	Legal Fees		Highlander Care Center, LLC	100.00%	219	219	6
7	V	21	LLC Fee		Highlander Care Center, LLC	100.00%	200	200	7
8	V	21	Trust Fee		Highlander Care Center, LLC	100.00%	90	90	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 926,991			\$ 1,313,961	\$ * 386,970	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	05	Utilities	\$	Care Centers, Inc.	100.00%	\$ 1,377	\$ 1,377	15
16	V	06	Maintenance		Care Centers, Inc.	100.00%	2,694	2,694	16
17	V	10	Nursing	40	Care Centers, Inc.	100.00%	7	(33)	17
18	V	11	Activities		Care Centers, Inc.	100.00%	2	2	18
19	V	19	Professional Fees	305,743	Care Centers, Inc.	100.00%	8,022	(297,721)	19
20	V	20	Dues and Subscriptions	19,893	Care Centers, Inc.	100.00%	1,065	(18,828)	20
21	V	21	Office & Clerical		Care Centers, Inc.	100.00%	13,283	13,283	21
22	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	793	793	22
23	V	26	Insurance		Care Centers, Inc.	100.00%	969	969	23
24	V	30	Depreciation		Care Centers, Inc.	100.00%	9,492	9,492	24
25	V	32	Interest		Care Centers, Inc.	100.00%	10,124	10,124	25
26	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	2,389	2,389	26
27	V	34	Rent - Building		Care Centers, Inc.	100.00%	3,691	3,691	27
28	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	2,682	2,682	28
29	V	25	Bus Reimbursement	-	Care Centers, Inc.	100.00%			29
30	V	02	Food	119	Care Centers, Inc.	100.00%		(119)	30
31	V	17	Administration		Care Centers, Inc.	100.00%	324	324	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 325,795			\$ 56,914	\$ * (268,881)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping Salary	\$	Care Centers, Inc.	100.00%	\$	\$	15
16	V	06	Maintenance Salary	1,444	Care Centers, Inc.	100.00%	1,444		16
17	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	197	197	17
18	V	10	Nursing Salary	68,327	Care Centers, Inc.	100.00%	67,128	(1,199)	18
19	V	10a	Rehab Salary	5,089	Care Centers, Inc.	100.00%	5,095	6	19
20	V	11	Activity Salary	4,057	Care Centers, Inc.	100.00%	4,079	22	20
21	V	12	Social Service Salary	20,945	Care Centers, Inc.	100.00%	7,774	(13,171)	21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	13,432	13,432	22
23	V	17	Administration Salary	73,993	Care Centers, Inc.	100.00%	74,012	19	23
24	V	21	Office Salary	29,002	Care Centers, Inc.	100.00%	42,173	13,171	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	13,823	13,823	25
26	V	22	Employee Benefits	30,249	Care Centers, Inc.	100.00%		(30,249)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 233,106			\$ 229,157	\$ * (3,949)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	\$ 7,957	Care Centers, Inc.	100.00%	\$ 4,196	\$ (3,761)	15
16	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	1,593	1,593	16
17	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	782	782	17
18	V	10	Nursing Salary		Care Centers, Inc.	100.00%	9,873	9,873	18
19	V	12	Social Service Salary		Care Centers, Inc.	100.00%	11	11	19
20	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,360	1,360	20
21	V	17	Administration Salary		Care Centers, Inc.	100.00%	27,582	27,582	21
22	V	21	Office Salary		Care Centers, Inc.	100.00%	78,752	78,752	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	14,981	14,981	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 7,957			\$ 139,130	\$ * 131,173	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	\$ 4,251	Care Centers, Inc. - Health Systems Division	100.00%	\$ 1,250	\$ (3,001)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	1,173	1,173	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	10	10	17
18	V	10	Nursing		Care Centers, Inc. - Health Systems Division	100.00%	6	6	18
19	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	158	158	19
20	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	317	317	20
21	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	17	17	21
22	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	227	227	22
23	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	339	339	23
24	V	34	Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	9	9	24
25	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	13	13	25
26	V	39	Ancillary Enteral Supplies	10,765	Care Centers, Inc. - Health Systems Division	100.00%	5,123	(5,642)	26
27	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	2,994	2,994	27
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	402	402	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 15,016			\$ 12,038	\$ * (2,978)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	\$ 65,053	XCEL Medical Supply, LLC	100.00%	\$ 56,240	\$ (8,813)	15
16	V	03	Housekeeping	10,842	XCEL Medical Supply, LLC	100.00%	9,373	(1,469)	16
17	V	10	Nursing	44,574	XCEL Medical Supply, LLC	100.00%	38,535	(6,039)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 120,469			\$ 104,148	\$ * (16,321)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 70,931	\$ 70,931	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	70,931				(70,931)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 70,931			\$ 70,931	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Relative	Administrative		see attached	1.59	2.21%		\$		1
2	Mark Steinberg	Relative	Administrative		see attached	1.62	3.24%	CCI alloc.	1,468	17-7	2
3	Melissa Rothner	Owner	Clerical	2.29%	see attached			CCI alloc.	33	21-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,501		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

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	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/02

(847) 905-3030

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/02

(847) 905-3030

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/02

(847) 905-3030

Fax Number**SEE ACCOUNTANTS' COMPILATION REPORT**

Ending: 12/31/02

(847) 905-3030

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Xcel Medical Supply, LLC
Street Address 2201 Main Street
City / State / Zip Code Evanston, IL 60202
Phone Number (847) 328-7600
Fax Number (847) 328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Direct Allocation			\$	\$		\$ 56,240	1
2	03	Housekeeping	Direct Allocation						9,373	2
3	10	Nursing	Direct Allocation						38,535	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 104,148	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address 2201 W. MAIN ST.
City / State / Zip Code EVANSTON, IL 60202
Phone Number (847) 905-4000
Fax Number (847) 905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			\$	\$		\$ 70,931	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 70,931	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

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	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number INTERNATIONAL VILLAGE # 0041590 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	Corrus Bank		X	Construction Loan			\$	9,207,954			\$	778,962	1	
2	Corrus Bank		X	Second Mortgage				780,000				53,179	2	
3													3	
4													4	
5													5	
	Working Capital													
6	Diawa	X		Working Capital				3,962,290				7,032	6	
7	Shareholder Loan	X		Working Capital				600,000				5,395	7	
8	Hunter Management											23,000	8	
9	TOTAL Facility Related						\$	14,550,244				\$	867,568	9
	B. Non-Facility Related*													
10	See Supplemental Schedule											5,408	10	
11	Intercompany											185,023	11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$					\$	190,431	14
15	TOTALS (line 9+line14)						\$	14,550,244				\$	1,057,999	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income						\$				\$ (4,716)	1
2	Care Center allocation										10,124	2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							\$				\$ 5,408	21

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2001 report.		\$	<u>354,135</u>		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>359,589</u>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>5,454</u>		3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>316,560</u>		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	<u>12,603</u>		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>334,617</u>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1997		8	
		1998		9	
		1999		10	
		2000	<u>5,865</u>	11	
		2001	<u>357,200</u>	12	
<u>Real estate tax paid during the year: Year 2000 \$ 55,712</u>					
<u>Year 2001 \$301,488</u>					
<u>Total \$357,200</u>					
<u>2002 accrual = 2001 expense + 5% (\$301,488 x 105% = \$316,560)</u>					
<u>Care Centers allocation \$2389</u>					
		FOR OHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2001 \$		13
		14	PLUS APPEAL COST FROM LINE 5 \$		14
		15	LESS REFUND FROM LINE 6 \$		15
		16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

INTERNATIONAL VILLAGE

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0041590

CONTACT PERSON REGARDING THIS REPORT

STEVEN LAVENDA

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1155

- A. Summary of Real Estate Tax Cost
- Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>20-07-104-001-0000</u>	<u>Long Term Care Property</u>	<u>\$ 218,698.71</u>	<u>\$ 218,698.71</u>
2.	<u>20-07-104-003-0000</u>	<u>Long Term Care Property</u>	<u>\$ 944.50</u>	<u>\$ 944.50</u>
3.	<u>20-07-104-004-0000</u>	<u>Long Term Care Property</u>	<u>\$ 806.97</u>	<u>\$ 806.97</u>
4.	<u>20-07-104-005-0000</u>	<u>Long Term Care Property</u>	<u>\$ 338.29</u>	<u>\$ 338.29</u>
5.	<u>20-07-104-009-0000</u>	<u>Long Term Care Property</u>	<u>\$ 72,089.73</u>	<u>\$ 72,089.73</u>
6.	<u>20-07-104-011-0000</u>	<u>Long Term Care Property</u>	<u>\$ 7,620.23</u>	<u>\$ 7,620.23</u>
7.	<u>20-07-104-012-0000</u>	<u>Long Term Care Property</u>	<u>\$ 989.81</u>	<u>\$ 989.81</u>
8.	<u>20-07-104-001-0000</u>	<u>Long Term Care Property</u>	<u>\$ 41,873.51</u>	<u>\$ 41,873.51</u>
9.	<u>20-07-104-009-0000</u>	<u>Long Term Care Property</u>	<u>\$ 13,838.42</u>	<u>\$ 13,838.42</u>
10.	<u>see attached</u>	<u>Home office allocation</u>	<u>\$ 70,261.69</u>	<u>\$ 2,277.96</u>
		TOTALS	\$ 427,461.86	\$ 359,478.13

- B. Real Estate Tax Cost Allocations
- Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)
- C. Tax Bills
- Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

INTERNATIONAL VILLAGE

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0041590

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,132

B. General Construction Type: Exterior BrickFrame SteelNumber of Stories 3

C. Does the Operating Entity?

☐ (a) Own the Facility☒ (b) Rent from a Related Organization.☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment☒ (b) Rent equipment from a Related Organization.☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?☒ YES☐ NO

If so, please complete the following:

1. Total Amount Incurred: 542,866

2. Number of Years Over Which it is Being Amortized: 5

3. Current Period Amortization: 113,442

4. Dates Incurred: Prior to 9/11/00

Nature of Costs: Organization Cost, Pre-operating Costs

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	115,710	1995	\$ 901,533	1
2	Care Centers allocation			13,636	2
3	TOTALS	115,710		\$ 915,169	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9								-		-	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$ -	\$	\$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		12,663,604	325,288		362,331	37,043	811,886	68
69	Financial Statement Depreciation			24,370			(24,370)		69
70	TOTAL (lines 4 thru 69)		\$ 12,663,604	\$ 349,658		\$ 362,331	\$ 12,673	\$ 811,886	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward	\$ 12,815,701	\$ 349,658		\$ 369,934	\$ 20,276	\$ 829,380	1
2	2000	1,871		20	94	94	219	2
3	SPRINKLER	3,000		20	150	150	350	3
4	HAGEMASTER DEBRIS	4,880		20	244	244	569	4
5	TELEPHONE WIRING	642		20	32	32	75	5
6	SIGNS	(4,710)		20	(4,611)	(4,611)	(4,926)	6
7	SIGNS	5,260		20	263	263	614	7
8	TELEPHONE WIRING	4,542		20	227	227	530	8
9	ELECTRICAL WIRING	375		20	19	19	40	9
10	ELECTRICAL WIRING	421		20	21	21	44	10
11	ELECTRICAL WIRING	656		20	33	33	69	11
12	STORAGE SYSTEMS	7,961		20	398	398	796	12
13	TELEPHONE WIRING	562		20	28	28	56	13
14	CCTV	1,196		20	60	60	120	14
15	CCTV	641		20	32	32	64	15
16	DRAPERY	2,324		20	116	116	222	16
17	CUBICLE CURTAINS	1,632		20	82	82	157	17
18	TELEPHONE WIRING	419		20	21	21	39	18
19	TELEPHONE WIRING	555		20	28	28	51	19
20	TELEPHONE WIRING	419		20	21	21	39	20
21	SURGE SUPPRESSOR	860		20	43	43	79	21
22	TELEPHONE WIRING	592		20	30	30	53	22
23	TELEPHONE WIRING	681		20	34	34	60	23
24	TELEPHONE WIRING	617		20	31	31	54	24
25	TELEPHONE WIRING	690		20	35	35	64	25
26	TELEPHONE WIRING	296		20	15	15	25	26
27	TELEPHONE WIRING	691		20	35	35	58	27
28	TELEPHONE WIRING	617		20	31	31	52	28
29	SATELLITE	1,454		20	73	73	122	29
30	TELEPHONE WIRING	839		20	42	42	67	30
31	TELEPHONE WIRING	518		20	26	26	41	31
32	TELEPHONE WIRING	395		20	20	20	32	32
33	TELEPHONE WIRING	321		20	16	16	25	33
34	TOTAL (lines 1 thru 33)	\$ 12,856,918	\$ 349,658		\$ 367,623	\$ 17,965	\$ 829,240	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 12,856,918	\$ 349,658		\$ 367,623	\$ 17,965	\$ 829,240	1
2	TELEPHONE WIRING	2001	358		20	18	18	29	2
3	IRON FENCE	2001	3,800		20	190	190	285	3
4	TELEPHONE WIRING	2001	1,911		20	96	96	144	4
5	TELEPHONE WIRING	2001	1,036		20	52	52	74	5
6	PLUMBING	2001	5,169		20	258	258	344	6
7	SPRINKLER SYSTEM REP	2001	518		20	26	26	35	7
8	HVAC	2001	625		20	31	31	41	8
9	TELEPHONE WIRING	2001	913		20	46	46	58	9
10	ANTI-FREEZE SPRINKLE	2001	1,320		20	66	66	83	10
11	CLEARING LOT	2001	4,847		20	242	242	303	11
12	TELEPHONE WIRING	2001	863		20	43	43	54	12
13	LANDSCAPING	2001	3,452		20	173	173	274	13
14	CODE ALERT	2001	693		20	35	35	44	14
15	HVAC	2001	875		20	44	44	55	15
16	Telephones	2002	804		20	80	80	80	16
17	LIGHT TIMMER & CONTROL BOARD	2002	1,101		20	110	110	110	17
18	PHONE WIRING	2002	518		20	52	52	52	18
19	PHONE WIRING	2002	1,133		20	113	113	113	19
20	BOILER WORK-VARIUS INVOICES	2002	8,330		20	764	764	764	20
21	TELEPHONE WORK	2002	592		20	54	54	54	21
22	TELEPHONE WORK	2002	2,300		20	192	192	192	22
23	CHECK & ADJUST SYSTEM	2002	701		20	47	47	47	23
24	TELEPHONES	2002	2,111		20	123	123	123	24
25	ROOF REPAIRS	2002	1,246		20	73	73	73	25
26	REPAIR ELEVATOR DOOR-3RD FLOOR-FIRE DAMAGE	2002	3,201		20	320	320	320	26
27	REHANG ELEVATOR DOORS	2002	1,080		20	108	108	108	27
28	REPAIR BATHROOM SHOWERS	2002	1,858		20	77	77	77	28
29	ELEVATOR REPAIR	2002	755		20				29
30	A/C CHILLER REPAIR	2002	7,380		20				30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,916,408	\$ 349,658		\$ 371,056	\$ 21,398	\$ 833,176	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$12,916,408	\$349,658		\$371,056	\$21,398	\$833,176	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$12,916,408	\$349,658		\$371,056	\$21,398	\$833,176	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$12,916,408	\$349,658		\$371,056	\$21,398	\$833,176	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$12,916,408	\$349,658		\$371,056	\$21,398	\$833,176	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$12,916,408	\$349,658		\$371,056	\$21,398	\$833,176	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$12,916,408	\$349,658		\$371,056	\$21,398	\$833,176	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$12,916,408	\$349,658		\$371,056	\$21,398	\$833,176	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$12,916,408	\$349,658		\$371,056	\$21,398	\$833,176	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$12,916,408	\$349,658		\$371,056	\$21,398	\$833,176	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$12,916,408	\$349,658		\$371,056	\$21,398	\$833,176	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$12,916,408	\$349,658		\$371,056	\$21,398	\$833,176	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$12,916,408	\$349,658		\$371,056	\$21,398	\$833,176	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$12,916,408	\$349,658		\$371,056	\$21,398	\$833,176	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$12,916,408	\$349,658		\$371,056	\$21,398	\$833,176	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				2000	\$ 12,627,413	\$ 323,780	35	\$ 360,783	\$ 37,003	\$ 811,762	4
5	CCI allocation			1996		863	35	962	99		5
6	CCI allocation			2002	18,792	35	35	52	17	52	6
7											7
8											8
	Improvement Type**										
9	Care Centers allocation			2002		320	20	22	(298)		9
10	Care Centers allocation			2001		1	20	5	4		10
11	Care Centers allocation			2000		1	20	2	1		11
12	Care Centers allocation			1999		15	20	30	(15)		12
13	Care Centers allocation			1998		6	20	12	6		13
14	Care Centers allocation			1997		62	20	124	62		14
15	Care Centers allocation			1996		161	20	246	85		15
16	Care Centers allocation			1997		1	20	21	20		16
17	Care Centers allocation			1994		8	20		(8)		17
18	Care Centers allocation			1993		3	20		(3)		18
19	Care Centers allocation			2002	17,399	32	20	72	40	72	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$12,663,604	\$325,288		\$362,331	\$37,013	\$811,886	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,071,868	\$224,680	\$107,101	\$(117,579)	10	\$262,174	71
72	Current Year Purchases	48,952	1,206	21,482	20,276	10	21,482	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,120,820	\$225,886	\$128,583	\$(97,303)		\$283,656	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		CARE CENTERS ALLOCATION		\$21,841	\$3,674	\$3,183	\$(491)	5	\$11,944	76
77										77
78										78
79										79
80	TOTALS			\$21,841	\$3,674	\$3,183	\$(491)		\$11,944	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$14,974,238	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$579,218	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$502,822	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(76,396)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,128,776	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Care Centers allocation				3,691			5
6	Care Centers Health Systems allocation				9			6
7	TOTAL				\$ 3,700			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

16. Rental Amount for movable equipment: \$ 6,342 Description: Copier \$3367; Water Softener \$280; CCI alloc. \$2682; CCI Health Systems alloc. \$13

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$

13. /2004 \$

14. /2005 \$

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 68,580	\$		\$ 68,580	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			92,150			92,150	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			64,539			64,539	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				187,550		187,550	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						95,967		95,967	13
14	TOTAL			\$		\$ 225,269	\$ 283,517		\$ 508,786	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 495	\$ 495	1
2	Cash-Patient Deposits	25,120	25,120	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,553,262	2,553,262	3
4	Supply Inventory (priced at)		9,065	4
5	Short-Term Investments			5
6	Prepaid Insurance	138,867	138,867	6
7	Other Prepaid Expenses	8,759	8,759	7
8	Accounts Receivable (owners or related parties)	3,368,408	3,368,408	8
9	Other(specify): See Supplemental Schedule	27,636	60,336	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,122,547	\$ 6,164,312	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		901,533	13
14	Buildings, at Historical Cost		12,627,413	14
15	Leasehold Improvements, at Historical Cost	235,463	235,463	15
16	Equipment, at Historical Cost	291,437	1,090,094	16
17	Accumulated Depreciation (book methods)	(167,966)	(1,477,724)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	974	118,738	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 359,908	\$ 13,495,517	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,482,455	\$ 19,659,829	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 441,809	\$ 441,808	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,143	24,143	28
29	Short-Term Notes Payable	4,562,290	4,562,290	29
30	Accrued Salaries Payable	208,166	208,166	30
31	Accrued Taxes Payable (excluding real estate taxes)	26,414	26,414	31
32	Accrued Real Estate Taxes(Sch.IX-B)	316,560	316,560	32
33	Accrued Interest Payable	110,406	110,406	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	2,085,729	6,318,529	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,775,517	\$ 12,008,316	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,987,954	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 9,987,954	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,775,517	\$ 21,996,270	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,293,062)	\$ (2,336,441)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,482,455	\$ 19,659,829	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,434,483)	1
2	Restatements (describe):		2
3		(466)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,434,949)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	141,887	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 141,887	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,293,062)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,596,176	1
2	Discounts and Allowances for all Levels	(1,763,238)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,832,938	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,537,464	6
7	Oxygen	2,369	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,539,833	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	213,047	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,343	19
20	Radiology and X-Ray	7,970	20
21	Other Medical Services	116,964	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 358,324	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,716	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,716	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	186	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 186	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,735,997	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,119,224	31
32	Health Care	2,552,795	32
33	General Administration	1,726,354	33
	B. Capital Expense		
34	Ownership	1,567,596	34
	C. Ancillary Expense		
35	Special Cost Centers	508,786	35
36	Provider Participation Fee	119,355	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,594,110	40
41	Income before Income Taxes (line 30 minus line 40)**	141,887	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 141,887	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number INTERNATIONAL VILLAGE

0041590

Report Period Beginning:

01/01/02

Ending:

12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing	2,151	2,399	51,785	21.59	2
3	Registered Nurses	5,827	6,396	151,186	23.64	3
4	Licensed Practical Nurses	42,163	45,593	939,489	20.61	4
5	Nurse Aides & Orderlies	87,509	97,831	838,963	8.58	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,438	5,817	81,049	13.93	8
9	Activity Director	2,036	2,182	27,500	12.60	9
10	Activity Assistants	8,665	9,272	63,228	6.82	10
11	Social Service Workers	11,018	11,986	158,445	13.22	11
12	Dietician					12
13	Food Service Supervisor	2,700	3,250	46,976	14.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,057	19,991	147,186	7.36	15
16	Dishwashers					16
17	Maintenance Workers	3,460	3,904	60,729	15.56	17
18	Housekeepers	15,663	16,852	114,577	6.80	18
19	Laundry	6,247	6,474	44,861	6.93	19
20	Administrator					20
21	Assistant Administrator	1,968	2,208	38,833	17.59	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,293	10,414	105,562	10.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,888	2,096	20,878	9.96	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	224,083	246,665	\$ 2,891,247 *	\$ 11.72	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	260	\$ 10,330	01-03	35
36	Medical Director	monthly	8,250	09-03	36
37	Medical Records Consultant	64	2,880	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	3,978	10-03	39
40	Physical Therapy Consultant	29	1,566	10a-03	40
41	Occupational Therapy Consultant	25	1,593	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	46	2,208	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	<u>CCI (various - see attached)</u>		106,375		48
49	TOTAL (lines 35 - 48)	424	\$ 137,180		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	167	\$ 9,221	10-03	50
51	Licensed Practical Nurses	228	9,218	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	395	\$ 18,439		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
Diane Hart	Asst Administrator	0	\$ 36,499	Workers' Compensation Insurance	\$	83,586	IDPH License Fee	\$ 400
Gershen Draiman	Admin in Training		2,334	Unemployment Compensation Insurance		61,233	Advertising: Employee Recruitment	21,322
				FICA Taxes		218,726	Health Care Worker Background Check	3,484
				Employee Health Insurance		67,771	(Indicate # of checks performed 219)	
				Employee Meals			Dues & Subscriptions	3,956
				Illinois Municipal Retirement Fund (IMRF)*			Licenses & Fees	3,086
				Misc Employee Welfare		2,161	Advertising & Promotion	56,853
				Chicago Employee Tax		4,048	Yellow Page Advertising	100
				Pension Expense		5,137	Care Centers allocation	1,065
TOTAL (agree to Schedule V, line 17, col. 1)							Care Centers Health Systems alloc.	17
(List each licensed administrator separately.)							Less: Public Relations Expense	()
B. Administrative - Other							Non-allowable advertising	(56,853)
Description			Amount				Yellow page advertising	(100)
Administrative payroll paid by CCI (adjusted out on 6B)			\$ 72,794					
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V,	\$	442,662		
(Attach a copy of any management service agreement)				line 22, col.8)				
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Various - See attached	Legal		\$ 11,317				Out-of-State Travel	\$
Various - See attached	Computer Support		1,495					
Various - See attached	Accounting		28,753					
Care Centers, Inc.	Various - See attached		305,743				In-State Travel	
National Hotline	Compliance Phone Service		187					
Alpha Data	Payroll Services		4,467					
Urban Real Estate Research	Appraisal (RE Tax)		3,500				Seminar Expense	1,599
Cindy Zola	IOC Consulting		33				Care Centers allocation	793
Personnel Planners	Unemployment Consult		1,080				Care Centers Health Systems alloc.	339
TEG Services	Utility Management		225					
SAS Architect	Architect		119				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,	
(If total legal fees exceed \$2500 attach copy of invoices.)							line 24, col. 8)	\$ 2,731

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		INTERNATIONAL VILLAGE		STATE OF ILLINOIS				Page 23
		#	0041590	Report Period Beginning:	01/01/02	Ending:	12/31/02	

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

Yes

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

Yes
ICLTC \$5467

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

Yes
Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
10 yrs

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 2,145 Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

(9)

Are you presently operating under a sublease agreement?

YES X NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 119,355

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)
If YES, attach a schedule which explains how all related costs were allocated to these functions.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$
Indicate the amount. \$

(16)

Travel and Transportation
a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

No
None
N/A
N/A
N/A

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:
The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?
If no, please explain.

No

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees

Yes

SEE ACCOUNTANTS' COMPILATION REPORT